MONEY FOLLOWS THE PERSON

MFP	MFP	MFP	MFP	MFP	MFP	MFP	MFP	MFP	MFP	MFP

The purpose of this form is to:

1. Track MFP days
2. Provide statistics to CMS on reasons for readmission

This form does not replace the requirement for a CP-23 when indicated.

Participant's Name: _____

1. Start date (day of move to community): _____
   This is the date of discharge from the NF to the community setting, day one (1) of the 365 days under the MFP program

2. Date of Nursing Facility readmission: _____ **OR** Hospital admit over 30 days: _____
   If applicable, if after a hospitalization participant requires a NF stay or if participant enters a NF for any reason (see below)

3. Reason for readmission:

   - ☐ Needs exceed available/allowable services
   - ☐ Change in caregiver status, unable to provide care as before
   - ☐ Illness/deterioration in ADL function requiring NF stay
   - ☐ Decrease in cognitive function
   - ☐ Decrease in mental health
   - ☐ Loss of housing
   - ☐ Request of Guardian and/or participant

4. Date of discharge back to community: _____
   This date will restart the clock for a total of 365 days (days in the NF are not counted as part of the 365)

5. Number of days spent in NF: _____
   See above, number of days need to be monitored

6. Date of MFP Termination: _____

   Reason:

   - ☐ No longer meets Level of Care/withdrawn (attach CP-23)
   - ☐ Transferred into Assisted Living Residence
   - ☐ Expired (reason): _____
   - ☐ Other: _____

Please fax this form to the MFP Liaison in one of the OCCO offices below:

Northern OCCO fax 732-777-4681 (phone - 732-777-4650)
Southern OCCO fax 609-704-6055 (phone - 609-704-6050)

Care Manager's signature: _____

CM phone #: _____ CM fax #: _____